for each hospital. Second, the SSI days were multiplied by each hospital's Medicare inpatient charge per day for year ending June, 1989. Third, the resulting product was divided by total gross revenue and added to the percentage of Medicaid revenue.

The results of the estimation procedure for FY1989 are shown in Exhibit 1. Exhibit 2 shows the input data for each hospital used in the analysis.

The regression equations based on Fiscal Year 1988 and FY 1989 data allowed for a direct pass-through of the Medicaid day limit. The implementation of the pass-through is clearly seen in the construction of the dependent variable BDCHARD3 where the revenue effect of the Medicaid day limit is subtracted from a hospital's uncompensated care percentage prior to estimation. Once the predicted values are established, the Medicaid day limit dollars are added back to permit the pass-through.

Since the uncompensated care policy was adopted in 1983, the estimated regression equation has performed well in explaining variation in levels of uncompensated care, thereby providing confidence in its capacity as a test for reasonableness. Two statistics calculated from an estimation procedure, which indicate how much of the total variation in the dependent variable is explained by the regression model, are R^2 and F value. The most recent bad debt regression had an R^2 of .66 indicating that the independent variables explained roughly 66% of the total variation in the dependent variable. The F-value for the overall regression was 22.352 which is well above the critical value, indicating that the explanatory variables as a whole are jointly significant in predicting bad debt.

The second part of the three-tiered methodology uses the results of ordinary least squares estimation of the regression equations parameters, and calculates a predicted amount of uncompensated care as a percentage of revenue for each hospital in the State. Using the

results from the FY1989 bad debt regression and fictitious values of hospital input data, an example of the predicted bad debt calculation is developed below:

Assume Hospital A has the following data:

BDCHARD2	=	.11520
STATE89	=	160222
RDLOUT	=	0.0
RELE	=	22500
MCAIDSSI	=	28017
PIPCOMM	=	04500
URBAN	=	86700
EMGNMCAR	=	33.40

Then

BDCHARD3 = (.11520 - (160222/1000/(22500 - 0.0)))

= .10508

Hospital A's predicted level of uncompensated care is calculated as:

PREDBD = (0.02326886 * 1) + (0.19134552 * 0.28017) + (0.03106133 * 0.86700) + (0.001349830 * 33.40)

= .10914

Adding back the dollars removed for Medicaid state day limits, the final predicted level of bad debt used for policy purposes is:

PREDBDF = .10914 + .00712 = .11626

Note that Hospital A's predicted level of uncompensated care (11.63% is slightly greater than its actual level of bad debt (11.52%).

The final step in the Uncompensated Care Methodology is to determine the amount of bad debt to be included in rates as part of the Inflation Adjustment System process for each hospital. The final determination is made by comparing the predicted amount to both the amount currently in rates and the amount of uncompensated care actually incurred. A hospital's relative efficiency, measured by its screening position and its profit position, are also considered in arriving at the new amount of bad debt in rates. More specifically, the following criteria are used to determine the uncompensated care provision:

1. If a hospital is below the screening statewide average, then it is given the lower of either the predicted amount or the higher of actual or amount in rates. In other words, if the predicted amount is lower than the actual amount, then the hospital is given the predicted amount. However, if the actual amount is lower than the predicted amount, then the actual level is compared to the amount currently in rates and the hospital receives the higher of the two.
2. If a hospital is above the screening statewide average but the amount by which it is above the screening average is less than twice factor cost inflation and the hospital is not making a profit, then the policy described in (1) is applied.
3. If a hospital is less than twice factor cost inflation above the screening statewide average and is making a profit, then the hospital receives the lower of the predicted amount or the amount currently in rates.
4. If a hospital is on a spenddown agreement, it has its uncompensated care provision adjusted according to (2) or (3) above depending on its profit position.

Returning to the example developed with Hospital A, assume Hospital A has the following data:

Screen result = 5.00% below statewide average

Profit margin = 475.000

PREDBDF = 11.62%

Amount in Rates = 9.00%

Actual = 11.52%

Hospital A is below the screening statewide average, and its predicted amount of bad debt is higher than its actual amount; thus, it does not receive the predicted amount. Comparing the amount currently in rates with the actual bad debt experience, Hospital A's actual bad debt percentage is greater than the amount urrently in rates. Hospital A's new uncompensated care allowance is 11.52%, a 2.52% increase over its current provision.

An evaluation of the input data and the final allowance for uncompensated care in rates indicates that hospitals with comparatively high levels of revenue attributed to Medicaid patients receive comparatively high provisions for bad debt. Thus, the Uncompensated Care Methodology assures that hospitals serving a disproportionate share of Medicaid patients are compensated for the expenses incurred through, at least a minimum as required under federal law and as provided for in B, Page 2-A1, Attachment 4.19 A&B. Furthermore, the uncompensated care methodology permits upward and downward adjustments in rates and encourages efficiency in hospital operations.

Reimbursement Methodology: STEPS Case Management

1. Requests for payment of STEPS case management services rendered shall be submitted according to procedures established by the Department. Payment requests which are not properly prepared or submitted may not be processed, but returned unpaid to the provider.
2. Requests for payment shall be submitted on the form specified by the Department.
3. STEPS case management providers shall bill the program $90 per participant for initial case management (only one unit of service may be reimbursed during the initial 60 days following the beginning of STEPS case management). Ongoing STEPS case management shall be reimbursed at the rate of $15 per unit of service (only one unit of service may be reimbursed per month).
4. The Department may not pay for case management claims received by the Program for payment more than 12 9 months after the completed service date.
5. Claims for case management services completed on different dates and submitted on a single form shall be received by the Program within 12 9 months of the earliest completed service date.
6. A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Program within the original 12 9-month period, or within 60 days of rejection, whichever is later.
7. Payments shall be made only to a qualified STEPS case management provider.

Reimbursement Methodology - HIV Targeted Case Management Services

1. Requests for payment of HIV targeted case management services rendered shall be submitted by an approved provider according to procedures established by the Department of Health and Mental Hygiene. Payment requests which are not properly prepared or submitted may not be processed, but will be returned unpaid to the provider.

2. Requests for payments shall be submitted on the invoice form specified by the Department of Health and Mental Hygiene. The completed form shall indicate the date(s) of service; name and Medical Assistance number of recipient; provider name, identification number, and location; and the nature, procedure code or codes, and unit(s) of covered service provided.

3. Providers shall bill the Program for the appropriate fee as specified in #4(c) below.

4. Payments shall be made:

a) Only to a qualified provider of HIV targeted case management, for covered services rendered to a participant;

b) Only to one provider for a specific type of HIV targeted case management services rendered to a participant during a specified time period; and

c) According to the following fee-for-service schedule for HIV targeted case management:

	Description	Fee Per Unit of Service
1)	One completed multidisciplinary assessment or reassessment performed by an HIV diagnostic evaluation services provider	$200
2)	Participation by the case manager in one completed multidisciplinary assessment or reassessment	$100
3)	Ongoing case management (no more than one unit of service may be reimbursed per calendar month.)	$100

5. The Department may not pay for claims received by the Program for payment more than 6 months after the completed service date.

6. Claims for services completed on different dates and submitted on a single form shall be received by the Program within 6 months of the earliest completed service date.

7. A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Maryland Medical Assistance Program within the original 6-month period, or within 60 days of rejection, whichever is later.

8. If the recipient has insurance or if any other person is obligated either legally or contractually to pay for, or to reimburse the recipient for any HIV targeted case management covered service, the provider shall seek payment from that source first. If payment is made by both the Program and the insurance or other source, the provider shall report, within 15 days after the close of each month, on a form designated by the Department, the amount paid by the Program, and the insurance or the other source, whichever is less, and refund the total amount of the lesser of the two payments reported to the Program at that time.

9. If refund or a payment, as specified above, is not made, the Department will have the right to reduce its current payment to the provider by the amount of the duplicate payment, over-payment, or third party payment.

Reimbursement Methodology for Nutritionists' and Dietitians' Services:

A. Request for Payment

(1) Requests for payment of Healthy Start Program services rendered and completed shall be submitted by an approved provider according to procedures established by the Department of Health and Mental Hygiene. Payment requests which are not properly prepared or submitted may not be processed, but shall be returned unpaid to the provider.

(2) Requests for payment shall be submitted on the invoice form specified by the Department of Health and Mental Hygiene. A separate invoice shall be submitted for each participant. The completed form shall indicate the:

(a) Date or dates of service;

(b) Participant's name and Medical Assistance number;

(c) Provider's name, location, and provider number; and

(d) Nature, unit or units, and procedure code or codes of covered services provided.

(3) Providers shall bill the Medical Assistance Program for the appropriate fee specified in Section C below.

B. Billing Time Limitations

(1) The Department of Health and Mental Hygiene shall not pay for claims received by the Medical Assistance Program for payment more than ~~6~~ 9 months after the completed service date.

(2) Claims for services completed on different dates and submitted on a single form shall be received by the Medical Assistance Program within ~~6~~ 9 months of the earliest completed service date.

(3) A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Medical Assistance Program within the original ~~6~~ 9 month period, or within 60 days of rejection, whichever is later.

C. Payments shall be made:

(1) Only to a qualified provider for covered services rendered to a participant, as specified in these regulations;
(2) According to the following fee-for-service schedule for the High-Risk Nutritional Intervention Services.

Description	Fee Per Unit of Service
High-Risk Nutritional Intervention-Services:	
half-hour session	$20
one-hour session	$40

Reimbursement Methodology for Private Duty Nursing Services:

A. Request for Payment

(1) Requests for payment of Healthy Start Program services rendered and completed shall be submitted by an approved provider according to procedures established by the Department of Health and Mental Hygiene. Payment requests which are not properly prepared or submitted may not be processed, but shall be returned unpaid to the provider.

(2) Requests for payment shall be submitted on the invoice form specified by the Department of Health and Mental Hygiene. A separate invoice shall be submitted for each participant. The completed form shall indicate the:

(a) Date or dates of service;

(b) Participant's name and Medical Assistance number;

(c) Provider's name, location, and provider number; and

(d) Nature, unit or units, and procedure code or codes of covered services provided.

(3) Providers shall bill the Medical Assistance Program for the appropriate fee specified in Section C below.

B. Billing Time Limitations

(1) The Department of Health and Mental Hygiene shall not pay for claims received by the Medical Assistance Program for payment more than ~~6~~ 9 months after the completed service date.

(2) Claims for services completed on different dates and submitted on a single form shall be received by the Medical Assistance Program within ~~6~~ 9 months of the earliest completed service date.

(3) A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Medical Assistance Program within the original ~~6~~ 9 month period, or within 60 days of rejection, whichever is later.